

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 000426	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2012
NAME OF PROVIDER OR SUPPLIER NORTHERN LAKES NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 516 N WILLIAMS ST ANGOLA, IN 46703		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
K 000	<p>INITIAL COMMENTS</p> <p>A Quality Assurance Walk-thru Survey was conducted by the Indiana State Board of Health.</p> <p>Survey Date: 10/09/12</p> <p>Facility Number: 000426 Provider Number: 155449 AIM Number: 100275480</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Quality Assurance Walk-thru survey, Northern Lakes Nursing and Rehabilitation Center was found in compliance with 410 IAC 16.2-3.1-19(ff).</p> <p>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 150 and had a census of 77 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except a maintenance building including the maintenance office and tools, and an off site storage unit used for the storage of beds and mattresses.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/11/12.</p>	K 000			

Indiana State Department of Health

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

UY7921

If continuation sheet 1 of 2

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